STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD EXTENDED HEALTHCARE	1649 EAST 72ND TACOMA, WA 98404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Quality Indicator Survey conducted at Heartwood Extended Health Care on 9/3/13, 9/4/13, 9/5/13, 9/6/13, 9/9/13, 9/10/13 and 9/11/13. A sample of 33 residents was selected from a census of 101. The sample included 33 current residents and the closed records of 3 discharged residents.

The survey was conducted by:

[redacted] RN, BSN, MBA
[redacted] RN, BSN, MSN
[redacted] RN, BSN
[redacted] RN, MN
[redacted] RN, BSN, MSN

The survey team is from:

Department of Social and Health Services
Aging and Long Term Services Administration
Residential Care Services, District 3, Unit B
P.O. Box 45819, MS: N27-24
Olympia, Washington, 98504-5819

Telephone: (253) 983-3800
Fax: (253) 589-7240

9/16/13
Signature Date

RECEIVED
OCT 02 REC'D
DSHS - ADSA
RCS - REGION 5

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9-27-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined licensed staff failed to timely communicate a change in condition to appropriate health team members for 2 Sampled Residents (#134 & 184) who were reviewed for professional standards of care of the 33 residents who were included in the Stage 2 review. This resulted in delayed reassessment and alteration in plans of treatment for these residents. Findings include: According to "Lippincott Manual of Nursing Practice," ninth edition, the nursing process is a "deliberate, problem-solving approach to meeting the health care and nursing needs of patients." The process "involves assessment (data collection), nursing diagnosis, planning, and evaluation, with subsequent modifications used as feedback mechanisms to promote the resolution of the nursing diagnoses. The process as a whole is cyclical, with the steps being interrelated, interdependent, and recurrent." Implementation includes coordinating care with other health team members. RESIDENT #184 Refer to F 323 for resident observations, additional information and failure to timely assess for safe use of tilt and space wheelchair for	F 281	The facility will continue to ensure that professional standards of care and quality are met. Appropriate qualified persons will assess and communicate changes in residents. The facility has modified our communication mechanism to uniformly report to multiple disciplines. This will communicate need for further assessment. Further, the facility will implement a facility wide tool ("Stop and Watch" Interact tool). This will provide all staff a way to communicate a change noted in a resident's condition. Feedback and follow through will be implemented through assigned disciplines after review of referral books and "Stop and Watch" copies at daily morning meetings. Resident 184 has been re-assessed for the need and usage of enabling devices. Regular, standard wheelchair and use of seatbelt alarm was determined. Care plan updated to reflect this change. For resident 134 refer to response in F285. Inservices in review of referral books will be conducted for all staff with education of the usage of the "Stop and Watch" tool. This will be added to our orientation and at annual review. Compliance will be ensured by the Director of Nursing Services.	10/26/13

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F 281	Continued From page 2 Resident #184. The facility implemented a tilt and space wheelchair reclined at 30 degrees from an upright position for Resident #184 between 8/12/13 through 8/27/13. Nursing progress noted documented the resident made multiple attempts to climb out of the wheelchair while in a reclined position. On 9/10/13 at 10:17 a.m. Restorative Staff G reported he/she did not become aware of the resident's behavior to try to get out of the reclined wheelchair until 8/26/13. On 8/27/13 Staff G reported, following assessment, staff determined the need to alter the resident's plan of care to decrease the resident's risk for injury. Staff G also reported nursing staff did not verbally communicate or utilize a restorative referral book kept at the nurses' station to communicate to restorative services of the resident's attempts to climb out of the reclined wheelchair. Failure to timely communicate to appropriate interdisciplinary team members of Resident #184's behavior to attempt to climb out of a wheelchair when in a reclined position placed the resident at risk for injury. RESIDENT # 134 Refer to F 285 for additional information related to delayed request for specialized mental health services for Resident #134. Staff identified on 5/29/13 Resident #134 had a history of a mental health condition and took a psychoactive medication. Staff notified the	F 281		

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F 281	Continued From page 3 physician and obtained orders to administer the psychoactive medication to the resident as needed. The resident required increased use of the psychoactive medication between 5/31/13 and 8/15/13. On 9/9/13 at 8:09 a.m. Social Service Staff D reported as soon as he/she became of the resident ' s increased use of the medication he/she submitted a request on 8/15/13 for evaluation for specialized services. Staff D reported nursing staff did not communicate verbally or write a note in the referral book at the nursing station to request services from social services. On 9/10/13 at 1:02 p.m., Staff D reported the family and Resident #134 agreed to a change in plan of treatment to see if it could improve the resident's mental health status. Failure to timely communicate to social services Resident #134 had a history of a mental health condition requiring use of medication had the potential to delay a change in treatment to improve the resident's health status.	F 281		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)	F 285	The facility will continue to provide or arrange specialized services that are needed as a result of pre-admission screening in a timely manner. New admissions will be reviewed by Social Services or designee at morning meeting during business hours to review psychoactive medications and current PASRR. Referral to behavioral health will be made if indicated.	10/26/13

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F 285	Continued From page 4 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to timely request specialized services for 1 of 1	F 285	Communication referral book for Social Services will be reviewed at these times as well. Resident 134 – Appropriate parties were notified of the usage of psychoactive medication. Physician updated with no change in orders. Appropriate parties notified of need for PASRR completion. Resident 134 has been assessed for need of specialized services and referral has been made. Appropriate parties were notified. Inservices will be conducted for all staff for implementation of the "Stop and Watch" Interactive tool. This will also be reviewed upon hire, prn and annually. Licensed staff will be educated/inserviced on resident usage of the referral book. Random, ongoing audits will be implemented by Social Services Director. Director of Nursing Services will ensure compliance and implementation.	

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F 285	Continued From page 5 Sampled Residents (#134) reviewed for pre-admission screening requirements of the 33 residents who were included in the Stage 2 review. This had the potential for the resident's mental health needs to not be met. Findings include: Resident #134 was admitted to the facility on 5/14/13 following repair of a fractured hip. A Minimum Data Set (assessment tool) dated 5/20/13 identified, at the time of admission, the resident had impaired hearing and vision, and expressed some concerns related to mood. The resident's record did not identify the resident had a mental health condition or took psychoactive medications. On 9/4/13 at 2:17 p.m. Resident #134 sat in the room watching television behind a closed curtain. The resident participated in an interview and reported he/she preferred to stay in the room instead of participating in group activities. A Preadmission Screening form dated 5/14/13 used to determine if Resident #134 required a referral for mental health rehabilitative services identified the resident did not have a mental health condition at the time of admission. The form indicated the resident did not require a referral at this time. On 5/29/13 staff documented in progress notes the resident had "periods of anxiety." The note documented staff obtained additional information at this time that identified Resident #134 did have a history of anxiety that escalated into shortness of breath and took anti-anxiety medication for relief prior to admission.	F 285		

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F 285	Continued From page 6	F 285		

On 5/31/13 the physician directed staff to administer an anti-anxiety medication as needed at bedtime. Medication records documented staff administered medication to treat anxiety 13 times during June 2013. Notes on the reverse side of the record documented that the resident experienced symptoms that included restlessness or nervousness and received effective results from medication given.

On 7/18/13 a progress note documented Resident #134 was restless, called out and reported difficulty with breathing. Nursing staff contacted the physician and obtained an order to increase frequency of anti-anxiety medication use every six hours as needed. Medication records for July 2013 identified staff administered anti-anxiety medication 26 times during the month.

During August 2013, staff documented they administered anti-anxiety medication 25 times between 8/1/13 and 8/31/13.

On 8/15/13 the facility submitted a referral to request mental health specialized services. On 8/15/13 staff developed an individualized list of symptoms Resident #134 displayed when anxious for staff to monitor.

On 9/9/13 at 8:09 a.m. Staff D reported he/she did not become aware Resident # 134 had an anxiety disorder and increased use of anti-anxiety medication until 8/15/13. On 9/4/13 Staff D reported he/she became aware the resident's face would look fretful and tearful. Staff D confirmed the resident should have been reassessed earlier for mental health status and

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F 285	Continued From page 7 request for services should have been submitted sooner. Staff D reported a change in medication could be helpful for this resident. On 9/9/13 at 11:12 p.m. Staff F reported the facility had services available to residents to evaluate and treat mental health concerns. Failure to timely reassess and refer Resident #134 for a change in mental health status identified following admission had the potential to delay a change in the treatment plan to assist the resident to achieve the highest practicable level of psychosocial well-being. Refer to F 281 for failure to timely communicate change in mental health status for Resident #134 to social services.	F 285		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to either comprehensively assess and/or timely reassess and modify the plan of care related to use of a tilt and space wheelchair and/or lap belt for 1 of 3 Sampled Residents (#184) reviewed for	F 323	The facility will ensure that the resident environment remains as free of accident hazards s as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility has modified the policies on physical, restraint/enablers. This includes a 5, 14 and 30 day post admission review using the RAI. This will identify in a timely manner the need for implementing an enabling device. (See attachment Physical Restraint Enabler/Safety Assessment form) #1	10/26/13

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F 323	Continued From page 8 either restraints or accidents of the 33 residents who were included in the Stage 2 review. This placed Resident #184 at risk for injury related to use of these devices. Findings include: Resident #184 admitted to the facility on [redacted]13. Diagnosis included a [redacted] A Minimum Data Set (MDS, assessment tool) dated 8/19/13 identified the resident had difficulty recalling information, inattention and disorganized thinking, and sometimes could be understood by others when verbally communicating. On 9/5/13 at 8:43 a.m. and 11:00 a.m. Resident #184 sat upright in a wheelchair with a seat belt draped across his/her lap attached to the wheelchair. On 9/9/13 at 12:17 p.m. Resident #184 self-propelled in the hall while seated upright in a wheelchair with staff present. Staff present guided and re-directed the resident who attempted to enter another resident's room. Intermittently, the resident handled the latch on a lap belt attached to the wheelchair but did not unbuckle it. On 9/9/13 at 12:22 p.m. Staff H reported the resident wore the lap belt since it sounded an alarm if removed and alerted staff the resident tried to get up out of the wheelchair. On 9/10/13 at 8:04 a.m. Resident #184 handled the lap belt with both hands. The surveyor asked the resident if he/she could unbuckle the seatbelt. The resident handled the lap belt but did not	F 323	Re-assessment will continue with review at 5, 14, and 30 days post admit and/or through the RAI process. (See attached assessment) #2 Resident 184 has been re-assessed for need and use of enablers. It was determined that use of standard wheelchair and seat belt alarm were appropriate. Care Plan updated to reflect such. Rehab director educated on modified policy and expectations for assessment and re-assessment of enabling devices. These will be reviewed periodically by the IDT enabler committee ongoing and prn. The Director of Nursing Services will ensure compliance. 	

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F 323	Continued From page 9 attempt to unbuckle it and did not verbally respond to the question. An admission nursing note dated [redacted]/13 documented Resident #184 was "restless at times" and had an unsteady gait. A note dated 8/13/13 documented the resident "unable to follow simple directions." Progress nursing notes dated 8/12/13 identified during the evening of admission, staff implemented use of a tilt wheelchair for Resident #184 to be reclined 30 degrees from an upright position. An undated "Wheelchair Assessment" identified footrests were to be used at all times when staff tilted the wheelchair 30 degrees. When tilted in the wheelchair, the resident's reclined position would raise both legs off the ground and prevent feet from touching the floor. A progress note dated 8/13/13 at 3:00 p.m. documented Resident #184 made repeated attempts to stand and had periods of restlessness in the reclined position in the wheelchair. On 8/14/13 staff documented in a progress note at 6:30 p.m. Resident #184 made frequent attempts to arise from the wheelchair. On 8/19/13 at 12:45 p.m. a progress note indicated the resident continued "to attempt to get out of chair" and attempted to self-transfer. On 8/21/13 at 6:00 p.m. staff documented Resident #184 required frequent re-direction to keep on task and the resident made verbal responses to questions that did not make sense to staff or were "irrelevant."	F 323		

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F 323	Continued From page 10 On 8/23/13 a progress note documented Resident #184 had confusion and frequently attempted to stand up from or climb over the edge of a reclined wheelchair and the resident often could not state a reason for "restlessness." On 8/25/13 progress notes identified the resident had poor safety awareness, and occasional resistance to care when the resident did not understand information, intentions or expectations staff provided. A hand written note on the resident's care plan dated 8/27/13, noted staff discontinued the 30 degree tilt (15 days later) and placed the wheelchair more upright tilting it only 5 degrees. On 8/27/13 the care plan noted staff also implemented use of a self-releasing seatbelt for the resident to wear when seated in a wheelchair. On 9/10/13 at 10:17 a.m. Staff G reported if a resident tried to climb out of a tilt wheelchair staff should un-tilt the wheelchair to decrease the risk for injury. Staff G reported sometimes the resident would walk and other times got upset if he/she did not understand what staff would ask of him/her. When asked how the facility assessed for use of tilt wheelchairs and wheelchair lap belts (assistive devices), Staff G reported when a resident admitted, restorative staff assessed devices and nursing assessed for use of devices on evenings or weekends or if restorative nursing were not present. Staff G reported the process included assessment for fall risk and completion of a form	F 323		

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called "Physical Restraint/Enabler/Safety Device Assessment." The form Staff G showed the surveyor contained information that identified reasons, conditions or symptoms why the device would be used; diagnoses that contributed to risks for falls; previous interventions attempted; assistive devices recommended and benefits expected. The form did not contain a place to document or include an analysis to identify how and why staff determined benefits for using each specific assistive device would exceed risks associated with their use or how they determined if devices could potentially restrain or be safe for the resident to use.

Staff G looked in Resident #184's medical record and did not locate a completed "Physical Restraint/Enabler/Safety Device Assessment" form or evidence staff comprehensively assessed Resident #184 prior to implementing use of wheelchair reclined 30 degrees or a wheelchair lap belt. Staff G reported he/she sometimes documented assessments in progress notes prior to implementing devices. A progress note dated 8/27/13 documented staff changed the tilt on Resident #184's wheelchair from 30 degrees to 5 degrees and "added a self-releasing alarm seatbelt to alert staff to resident's needs."

Resident #184's medical record did not contain evidence staff documented an assessment for either the tilt wheelchair or the lap belt on the "Physical Restraint/Enabler/Safety Device Assessment" form that contained an analysis to identify how and why staff determined benefits for using each specific assistive device would exceed risks associated with their use or how they determined if the device could potentially restrain the resident. The record did not contain

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evidence staff reassessed if continued use of devices would be safe for this resident and how the resident's cognitive impairment, physical capability and/or behaviors impacted use of these devices.

On 9/10/13 at 11:03 a.m. Staff F reviewed Resident #184's record and did not locate evidence restorative or nursing staff conducted an initial comprehensive assessment for the tilt wheelchair.

On 9/10/13 at 3:00 p.m. Staff B confirmed either nursing or restorative staff should have completed assessments for Resident #184's assistive devices.

Although Resident #184 did not experience an injury related to the tilt and space wheelchair, failure to conduct an initial safety assessment or timely reassess use of the wheelchair and modify the plan of care when the resident attempted to climb out of it when in a reclined position placed the resident at increased risk for injury in the event the resident fell or tipped the wheelchair over.

Refer to F 281 for failure to timely communicate resident status related to use of a tilt wheelchair to other team members.